General

Guideline Title

Practice advisory for the prevention and management of operating room fires: an updated report by the American Society of Anesthesiologists Task Force on Operating Room Fires.

Bibliographic Source(s)

Apfelbaum JL, Task Force on Operating Room Fires. Practice advisory for the prevention and management of operating room fires: an updated report by the American Society of Anesthesiologists Task Force on Operating Room Fires. Anesthesiology. 2013 Feb;118(2):271-90. [108 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Society of Anesthesiologists Task Force on Operating Room Fires, Caplan RA, Barker SJ, Connis RT, Cowles C, de Richemond AL, Ehrenwerth J, Nickinovich DG, Pritchard D, Roberson D, Wolf GL. Practice advisory for the prevention and management of operating room fires. Anesthesiology. 2008 May;108(5):786-801; quiz 971-2. [93 references]

Recommendations

Major Recommendations

I. Education
- All anesthesiologists should have fire safety education, specifically for operating room (OR) fires, with emphasis on the risk created by an oxidizer-enriched atmosphere.

II. OR Fire Drills
- Anesthesiologists should periodically participate in OR fire drills, with the entire OR team. This formal rehearsal should take place during dedicated educational time, not during patient care.

III. Preparation
- For every case, the anesthesiologist should participate with the entire OR team (e.g., during the surgical pause) in assessing and determining whether a high-risk situation exists.
- If a high-risk situation exists, all team members—including the anesthesiologist—should take a joint and active role in agreeing on how a fire will be prevented and managed.
- Each team member should be assigned a specific fire management task to perform in the event of a fire (e.g., removing the tracheal tube, turning off the airway gases).
- Each team member should understand that his or her preassigned task should be performed immediately if a fire occurs, without

waiting for another team to take action.

- When a team member has completed a preassigned task, he or she should help other team members to perform tasks that are not yet complete.
- In every OR and procedure area where a fire triad can coexist (i.e., an oxidizer-enriched atmosphere, an ignition source, and fuel), an easily visible protocol for the prevention and management of fires should be displayed.
- Equipment for managing a fire should be readily available in every procedural location where a fire triad may exist.

IV. Prevention

- The anesthesiologist should collaborate with all members of the procedure team *throughout the procedure* to minimize the presence of an oxidizer-enriched atmosphere in proximity to an ignition source.
- For *all procedures*:
  - Surgical drapes should be configured to minimize the accumulation of oxidizers (oxygen and nitrous oxide) under the drapes and from flowing into the surgical site.
  - Flammable skin-prepping solutions should be dry before draping.
  - Gauze and sponges should be moistened before use in proximity to an ignition source.
- For *high-risk* procedures:
  - The anesthesiologist should notify the surgeon whenever there is a potential for an ignition source to be in proximity to an oxidizer-enriched atmosphere or when there is an increase in oxidizer concentration at the surgical site.
  - Any reduction in supplied oxygen to the patient should be assessed by monitoring (1) pulse oximetry and, if feasible, (2) inspired, exhaled, and/or delivered oxygen concentration.
- For *laser procedures*:
  - A laser-resistant tracheal tube should be used.
- The laser-resistant tracheal tube used should be chosen to be resistant to the laser used for the procedure (e.g., carbon dioxide, neodymium-doped yttrium aluminum garnet [Nd:YAG], argon [Ar], erbium-doped yttrium aluminum garnet [Er:YAG], potassium titanyl phosphate [KTP]).
  - The tracheal cuff of the laser tube should be filled with saline and colored with an indicator dye such as methylene blue.
  - Before activating a laser:
- The surgeon should give the anesthesiologist adequate notice that the laser is about to be activated.
- The anesthesiologist should:
  - *Reduce* the delivered oxygen concentration to the minimum required to avoid hypoxia.
  - *Stop* the use of nitrous oxide.
  - *Wait* a few minutes after reducing the oxidizer-enriched atmosphere before approving activation of the laser.
- For cases involving an *ignition source* and *surgery inside the airway*:
  - Cuffed tracheal tubes should be used when clinically appropriate.
  - The anesthesiologist should advise the surgeon against entering the trachea with an ignition source (e.g., electrosurgery unit).
  - *Before* activating an ignition source inside the airway:
- The surgeon should give the anesthesiologist adequate notice that the ignition source is about to be activated.
- The anesthesiologist should:
  - *Reduce* the delivered oxygen concentration to the minimum required to avoid hypoxia.
  - *Stop* the use of nitrous oxide.
  - *Wait* a few minutes after reducing the oxidizer-enriched atmosphere before approving the activation of the ignition source.
  - In some cases (e.g., surgery in the oropharynx), scavenging with suction may be used to reduce oxidizer enrichment in the operative field.
- For cases *involving moderate or deep sedation, an ignition source, and surgery around the face, head, or neck*:
  - The anesthesiologist and surgeon should develop a plan that accounts for the level of sedation and the patient's need for supplemental oxygen.
- If moderate or deep sedation is required or used, or if the patient exhibits oxygen dependence, the anesthesiologist and surgeon should consider a sealed gas delivery device (e.g., cuffed tracheal tube or laryngeal mask).
- If moderate or deep sedation is not required, and the patient does *not exhibit oxygen dependence*, an open gas delivery device (e.g., face mask or nasal cannula) may be considered.
  - *Before* activating an ignition source around the face, head, or neck:
- The surgeon should give the anesthesiologist adequate notice that the ignition source is about to be activated.
- The anesthesiologist should:
  - *Stop* the delivery of supplemental oxygen or reduce the delivered oxygen concentration to the minimum required to avoid hypoxia.

- *Wait* a few minutes after reducing the oxidizer-enriched atmosphere before approving the activation of the ignition source.

V. Management of OR Fires
   - When an early warning sign is noted, halt the procedure and call for an evaluation of fire.
   - When a fire is definitely present, immediately announce the fire, halt the procedure, and initiate fire management tasks.
   - Team members should perform their preassigned fire management tasks as quickly as possible:
     - Before the procedure, the team may identify a predetermined order for performing the tasks.
     - If a team member cannot rapidly perform his or her task in the predetermined order, other team members should perform their tasks without waiting.
     - When a team member has completed a preassigned task, he or she should help other members to perform tasks that are not yet complete.
   - For a fire in the *airway or breathing circuit*, as fast as possible:
     - Remove the tracheal tube.
     - Stop the flow of all airway gases.
     - Remove all flammable and burning materials from the airway.
     - Pour saline or water into the patient's airway.
   - For a fire *elsewhere on or in the patient*, as fast as possible:
     - Stop the flow of all airway gases.
     - Remove all drapes, flammable, and burning materials from the patient.
     - Extinguish all burning materials in, on, and around the patient (e.g., with saline, water, or smothering).
   - If the *airway or breathing circuit* fire is extinguished:
     - Reestablish ventilation by mask, avoiding supplemental oxygen and nitrous oxide, if possible.
     - Extinguish and examine the tracheal tube to assess whether fragments were left in the airway.
   - Consider bronchoscopy (preferably rigid) to look for tracheal tube fragments, assess injury, and remove residual debris.
     - Assess the patient's status and devise a plan for ongoing care.
   - If the fire *elsewhere on or in the patient* is extinguished:
     - Assess the patient's status and devise a plan for ongoing care of the patient.
     - Assess for smoke inhalation injury if the patient was not intubated.
   - If the fire is *not* extinguished after the first attempt (e.g., after performing the preassigned tasks):
     - Use a carbon dioxide fire extinguisher in, on, or around the patient.
     - If the fire persists after use of the carbon dioxide fire extinguisher:
     - Activate the fire alarm.
     - Evacuate the patient if feasible, following institutional protocols.
     - Close the door to the room to contain the fire and do not reopen it or attempt to reenter the room.
     - Turn off the medical gas supply to the room.
     - Follow local regulatory reporting requirements (e.g., report fires to your local fire department and state department of health).
     - Treat every fire as an adverse event, following your institutional protocol.

Clinical Algorithm(s)

A clinical algorithm for operating room fires is provided in the original guideline document.

Scope

Disease/Condition(s)

Injuries from operating room (OR) fires

Note: OR fires are defined as fires that occur on or near patients who are under anesthesia care, including surgical fires, airway fires, and fires within the airway circuit. A surgical fire is defined as a fire that occurs on or in a patient. An airway fire is a specific type of surgical fire that occurs in a patient's airway. Airway fires may or may not include fire in the attached breathing circuit.

Guideline Category

Management

Prevention

Risk Assessment

Clinical Specialty

Anesthesiology

Colon and Rectal Surgery

Neurological Surgery

Nursing

Orthopedic Surgery

Otolaryngology

Plastic Surgery

Surgery

Thoracic Surgery

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Hospitals

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

- To identify situations conducive to fire
- To prevent the occurrence of operating room (OR) fires
- To reduce adverse outcomes associated with OR fires
- To identify the elements of a fire response protocol
- To update the "Practice Advisory for Prevention and Management of Operating Room Fires: A Report by the American Society of Anesthesiologists Task Force on Operating Room Fires," adopted by the American Society of Anesthesiologists in 2007 and published in 2008

Note: This Advisory does not address fires away from the patient (e.g., in a trash can), institutional preplanning for fire, or the responses of fire personnel.

Target Population

Any patient having surgery in an operating room (OR)

Interventions and Practices Considered

Education and Prevention

1. Fire safety education specifically for operating room (OR) fires
2. Participation in OR fire drills with the entire OR team
3. Preparation for OR fires
    - Assessing and determining whether a high-risk situation exists
    - Team discussion of the strategy for the prevention and management of an OR fire in a high-risk situation
    - Each team member assigned a specific fire management task to perform
    - An easily visible protocol for the prevention and management of fires should be displayed
    - Equipment for managing a fire should be readily available
4. Prevention of OR fires
    - Minimizing or avoiding an oxidizer-enriched atmosphere near the surgical site
    - Safely managing ignition sources
    - Safely managing fuels

Management

1. Recognizing the early signs of fire
2. Halting the procedure
3. Making appropriate attempts to extinguish the fire
4. Following an evacuation protocol when medically appropriate
5. Delivering postfire care to the patient

Major Outcomes Considered

- Incidence of operating room (OR) fires
- OR fire-related morbidity and injuries
- OR fire-related mortality
- OR fire-related issues (e.g., psychological trauma, prolonged hospitalization, delay or cancellation of surgery, additional hospital resource utilization, liability)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

State of the Literature

For this updated Advisory, a review of studies used in the development of the original Advisory was combined with a review of studies published subsequent to approval of the original Advisory. The updated literature review was based on evidence regarding the efficacy of specific perioperative activities associated with the prevention and management of operating room (OR) fires. The evidence linkage interventions are listed below:

Education

- Fire safety education, with an emphasis on an oxidizer-enriched atmosphere

OR Fire Drills

- Periodic participation in OR fire drills.

Preparation

- Display an easily visible protocol for the prevention and management of fires.
- Preoperative determination of a high-risk situation.
- OR team discussion of OR fire strategy.

Prevention

- Minimizing or avoiding an oxidizer-enriched atmosphere near the surgical site.
- Configuring surgical drapes to minimize the accumulation of oxidizers.
- Reducing the concentration of supplied oxygen for *high-risk* procedures.
- Avoidance of nitrous oxide for high-risk procedures.
- Insufflating with room (medical) air during cases in or around the airway.
- Scavenging with suction during cases in or around the airway.
- Cuffed *versus* uncuffed tracheal tubes for cases in or around the airway.

Safely Managing Ignition Sources

- Electrocautery
- Electrosurgical devices
- Lasers

Safely Managing Fuels

- Drying of flammable skin-prepping solutions.
- Laser-resistant *versus* nonlaser-resistant tracheal tubes during laser surgery.
- Moistening of sponges and gauze when used in proximity to an ignition source.
- Filling the tracheal cuff of the laser tube with saline colored with an indicator dye.

Management

- Early signs of a fire include a flame or flash, unusual sounds, odors, smoke, or heat (observational).
- Removing the tracheal tube and stopping the flow of oxygen minimize patient injury after an *airway or breathing circuit* fire.
- Pouring saline into the patient's tracheal tube is effective in extinguishing an airway fire.

Scientific evidence used in the development of this updated Advisory is based on findings from literature published since the original Advisory was approved in 2007. Literature citations are obtained from PubMed and other healthcare databases, direct Internet searches, Task Force members, liaisons with other organizations, and from hand searches of references located in reviewed articles.

The updated electronic search covered a 6-year period from 2007 through 2012. The manual search covered a 10-year period from 2003 through 2012. Over 100 new citations that addressed topics related to the evidence linkages were identified. These articles were reviewed and combined with pre-2007 articles used in the original Advisory, resulting in a total of 124 articles that contained direct linkage-related evidence.

No evidence linkage contained sufficient literature with well-defined experimental designs and statistical information to conduct an analysis of aggregated studies (i.e., meta-analysis). A complete bibliography used to develop this updated Advisory, organized by section, is available as Supplemental Digital Content 2, http://links.lww.com/ALN/A905 .

Evidence also included survey data, testimony, internet commentary and Task Force opinion.

Number of Source Documents

A total of 124 articles contained direct linkage-related evidence.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Preparation of this update used the same methodological process as was used in the original Advisory to evaluate literature-based evidence. Opinion-based evidence obtained from the original Advisory is reported in this update. The protocol for reporting each source of evidence is described below.

Scientific Evidence

Findings from the aggregated literature are reported in the text of the Advisory by evidence category, level, and direction. Evidence categories refer specifically to the strength and quality of the *research design* of the studies. Category A evidence represents results obtained from randomized controlled trials (RCTs), and Category B evidence represents observational results obtained from nonrandomized study designs or RCTs without pertinent controls. When available, Category A evidence is given precedence over Category B evidence in the reporting of results. These evidence categories are further divided into evidence levels. Evidence levels refer specifically to the strength and quality of the summarized study findings (i.e., statistical findings, type of data, and the number of studies reporting/replicating the findings) within the two evidence categories. For this document, only the highest level of evidence is included in the summary report for each intervention. Finally, a directional designation of benefit, harm, or equivocality for each outcome is indicated in the summary report.

Category A

RCTs report comparative findings between clinical interventions for specified outcomes. Statistically significant (P <0.01) outcomes are designated as beneficial (B) or harmful (H) for the patient; statistically nonsignificant findings are designated as equivocal (E).

Level 1: The literature contains a sufficient number of RCTs to conduct meta-analysis, and meta-analytic findings from these aggregated studies are reported as evidence.

Note: Practice Advisories lack the support of a sufficient number of adequately controlled studies required to conduct an appropriate meta-analysis. Therefore, Category A1 evidence is not reported in this document.

Level 2: The literature contains multiple RCTs, but the number of RCTs is not sufficient to conduct a viable meta-analysis for the purpose of this Advisory. Findings from these RCTs are reported as evidence.

Level 3: The literature contains a single RCT, and findings from this study are reported as evidence.

Category B

Observational studies or RCTs without pertinent comparison groups may permit inference of beneficial or harmful relationships among clinical interventions and outcomes. Inferred findings are given a directional designation of beneficial (B), harmful (H), or equivocal (E). For studies that report statistical findings, the threshold for significance is P <0.01.

Level 1: The literature contains observational comparisons (e.g., cohort, case–control research designs) between clinical interventions for a specified outcome.

Level 2: The literature contains observational studies with associative statistics (e.g., relative risk, correlation, sensitivity/specificity).

Level 3: The literature contains noncomparative observational studies with descriptive statistics (e.g., frequencies, percentages).

Level 4: The literature contains case reports.

Insufficient Evidence

The *lack* of sufficient scientific evidence in the literature may occur when the evidence is either unavailable (i.e., no pertinent studies found) or

inadequate. Inadequate literature cannot be used to assess relationships among clinical interventions and outcomes, since such literature does not permit a clear interpretation of findings due to methodological concerns (e.g., confounding in study design or implementation) or does not meet the criteria for content as defined in the "Focus" of the Advisory.

Opinion-Based Evidence

All opinion-based evidence relevant to each topic (e.g., survey data, open-forum testimony, Web-based comments, letters, editorials) is considered in the development of this Advisory. However, only the findings obtained from formal surveys are reported.

Category A: Expert Opinion

Survey findings from Task Force–appointed expert consultants obtained during development of the original Advisory are summarized in the text and reported in appendix 2, table 2 of the original guideline document.

Category B: Membership Opinion

Survey findings from a random sample of active American Society of Anesthesiologists (ASA) members obtained during development of the original Advisory are summarized in the text and reported in appendix 2, table 3 of the original guideline document.

Survey responses from expert and membership sources are recorded using a five-point scale and summarized based on median values. When an equal number of categorically distinct responses are obtained, the median value is determined by calculating the arithmetic mean of the two middle values. Ties are calculated by a predetermined formula.

Strongly Agree: Median score of 5 (at least 50% of the responses are 5)

Agree: Median score of 4 (at least 50% of the responses are 4 or 4 and 5)

Equivocal: Median score of 3 (at least 50% of the responses are 3, or no other response category or combination of similar categories contains at least 50% of the responses)

Disagree: Median score of 2 (at least 50% of responses are 2 or 1 and 2)

Strongly Disagree: Median score of 1 (at least 50% of responses are 1)

Category C: Informal Opinion

Open-forum testimony during the development of the original Advisory, Internet-based comments, letters, and editorials are all informally evaluated and discussed during the formulation of Advisory statements. When warranted, the Task Force may add educational information or cautionary notes based on this information.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Literature

In the original Advisory, interobserver agreement among Task Force members and two methodologists was established by interrater reliability testing. Agreement levels using a κ statistic for two-rater agreement pairs were as follows: (1) type of study design, $\kappa = 0.63–0.82$; (2) type of analysis, $\kappa = 0.40–0.87$; (3) evidence linkage assignment, $\kappa = 0.84–1.00$; and (4) literature inclusion for database, $\kappa = 0.69–1.00$. Three-rater chance-corrected agreement values were: (1) study design, Sav = 0.69, Var (Sav) = 0.013; (2) type of analysis, Sav = 0.57, Var (Sav) = 0.031; (3) linkage assignment, Sav = 0.89, Var (Sav) = 0.004; and (4) literature database inclusion, Sav = 0.79, Var (Sav) = 0.025. These values represent moderate to high levels of agreement. For the updated Advisory, the same two methodologists involved in the original Advisory conducted the literature review.

Consensus-Based Evidence

For the original Advisory, consensus was obtained from multiple sources, including: (1) survey opinion from consultants who were selected based

on their knowledge or expertise in operating room (OR) fire prevention and management, (2) survey opinions solicited from a random sample of active members of the American Society of Anesthesiologists, (3) testimony from attendees of a publicly held open-forum at a national anesthesia meeting, (4) Internet commentary, and (5) Task Force opinion and interpretation. The survey rate of return was 52% (n = 38 of 73) for the consultants, and 64 surveys were received from a random sample of active American Society of Anesthesiologists members. Results of the surveys are reported in tables 2 and 3 and in the text of the Advisory in the original guideline document.

The consultants were asked to indicate which, if any, of the evidence linkages would change their clinical practices if the Advisory was instituted. The rate of return was 18% (n = 13 of 73). The percent of responding consultants expecting a change in their practice associated with each linkage topic was as follows: (1) education, 77%; (2) OR fire drills, 69%; (3) team discussion of fire strategy, 69%; (4) minimizing or avoiding an oxidizer-enriched atmosphere near the surgical site, 38%; (5) managing ignition sources, 38%; (6) managing fuels, 31%; (7) identification of a *high-risk* procedure, 85%; (8) management of a high-risk procedure, 31%; and (9) OR fire management, 77%. Eighty-five percent of the respondents indicated that the Advisory would have *no effect* on the amount of time spent on a typical case, and 15% indicated that there would be an increase of 1 to 5 minutes in the amount of time spent on a typical case with the implementation of this Advisory.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The original Advisory was developed by an ASA-appointed Task Force of nine members. These individuals included four anesthesiologists in private and academic practice from various geographic areas of the United States, an otolaryngologist, a perioperative registered nurse, a professional engineer/fire investigator, and two consulting methodologists from the ASA Committee on Standards and Practice Parameters.

The Task Force developed the Advisory by means of a seven-step process. First, they reached consensus on the criteria for evidence. Second, a systematic review and evaluation was performed on original, published, peer-reviewed and other research studies related to operating room (OR) fires. Third, a panel of expert consultants was asked to (1) participate in opinion surveys on the effectiveness of various strategies for fire prevention, detection, and management and (2) review and comment on a draft of the Advisory developed by the Task Force. Fourth, opinions about the Advisory were solicited from a random sample of active members of the ASA. Fifth, the Task Force held an open forum at a major national meeting‡ to solicit input on its draft recommendations. Sixth, the consultants were surveyed to assess their opinions on the feasibility of implementing this Advisory. Seventh, all available information was used to build consensus within the Task Force to create the final document.

‡ Society for Ambulatory Anesthesia, 22nd Annual Meeting; San Diego, California, May 5, 2007

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

A panel of expert consultants was asked to: (1) participate in opinion surveys on the effectiveness of various strategies for fire prevention, detection, and management, and (2) review and comment on a draft of the Advisory developed by the Task Force. Fourth, opinions about the

Advisory were solicited from a random sample of active members of the ASA. Fifth, the Task Force held an open forum at a major national meeting to solicit input on its draft recommendations. Sixth, the consultants were surveyed to assess their opinions on the feasibility of implementing this Advisory. Seventh, all available information was used to build consensus within the Task Force to create the final document.

The Guidelines were approved by the ASA House of Delegates on October 17, 2012.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

Evidence was obtained from two principle sources: scientific evidence and opinion-based evidence.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Prevention of operating room (OR) fires
- Reducing adverse outcomes associated with OR fires

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- Practice Advisories are systematically developed reports that are intended to assist decision-making in areas of patient care. Advisories provide a synthesis and analysis of expert opinion, clinical feasibility data, open-forum commentary, and consensus surveys. Practice Advisories developed by the American Society of Anesthesiologists (ASA) are not intended as standards, guidelines, or absolute requirements, and their use cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies.
- Practice Advisories are not supported by scientific literature to the same degree as standards or guidelines because of the lack of sufficient numbers of adequately controlled studies. Practice Advisories are subject to periodic update or revision as warranted by the evolution of medical knowledge, technology, and practice.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Clinical Algorithm

Mobile Device Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Safety

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Apfelbaum JL, Task Force on Operating Room Fires. Practice advisory for the prevention and management of operating room fires: an updated report by the American Society of Anesthesiologists Task Force on Operating Room Fires. Anesthesiology. 2013 Feb;118(2):271-90. [108 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2008 May (revised 2013 Feb)

Guideline Developer(s)

American Society of Anesthesiologists - Medical Specialty Society

Source(s) of Funding

American Society of Anesthesiologists

Guideline Committee

Task Force on Operating Room Fires and the Committee on Standards and Practice Parameters

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Society of Anesthesiologists Task Force on Operating Room Fires, Caplan RA, Barker SJ, Connis RT, Cowles C, de Richemond AL, Ehrenwerth J, Nickinovich DG, Pritchard D, Roberson D, Wolf GL. Practice advisory for the prevention and management of operating room fires. Anesthesiology. 2008 May;108(5):786-801; quiz 971-2. [93 references]

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) and EPUB for eBook devices from the Anesthesiology Journal Web site .

Print copies: Available from the American Society for Anesthesiologists, 520 North Northwest Highway, Park Ridge, IL 60068-2573.

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on July 9, 2008. The information was verified by the guideline developer on July 23, 2008. This summary was updated by ECRI Institute on July 8, 2013.

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